DELAWARE HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

COUNSELING APPOINTMENT INFORMATION RECORD

Name: _____ MCI #: _____ Date: _____

Is this an (check one): Initial Appointment _____ or Return Visit _____

1. Presenting problem:

_____

_____

_____

2. Current findings:

_____

_____

_____

_____

_____

3. Proposed Treatment Plan (length, frequency and number of visits requested): Initials

_____

_____

_____

_____

Next Appointment: _____ _____

Therapist Signature & Title